TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MEMORIAL COMPOUNDING PHARMACY

Respondent Name
AMERICAN ZURICH INSURANCE COMPANY

MFDR Tracking Number
M4-17-1700-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 6, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached bills are outstanding as we have not received any correspondence from the insurance carrier . . . We are now requesting Medical Fee Dispute Resolution."

Amount in Dispute: $726.61

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 28, 2016	Pharmacy services – compound drug dispensed	$726.61	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out procedures for resolving medical fee disputes.
2. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, receipt acknowledged February 14, 2017. Per Rule §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier has not responded. Accordingly, this decision is based on the information available at the time of review.

3. No explanations of benefits were submitted for review by either party. Rule §133.307(d)(2)(F) requires that the response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. As will be discussed further below, because the respondent has not supported that the insurance carrier took final action on the disputed bills and further failed to support that the insurance carrier communicated to the requestor any denial reasons or defenses prior to the filing of the request for MFDR, the division finds below that the respondent has waived any such defenses. Any new denial reasons or defenses presented in the insurance carrier's response shall not be considered in this review.

Issues

1. Did the workers' compensation insurance carrier respond to the request for medical fee dispute resolution?
2. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. The insurance carrier's Austin representative, Flahive, Ogden & Latson, acknowledged receipt of the MFDR request on behalf of the insurance carrier on February 14, 2017.

   28 Texas Administrative Code §133.307(d) requires that "responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division."

   Rule §133.307(d)(1) further requires that "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days** after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

   As of the date of this review, the division has not received any response information from the insurance carrier. The division concludes the respondent has failed to meet the requirements of Rule §133.307(d)(1). Consequently, this decision is based on the information available at the time of review.

2. This medical fee dispute involves prescription drugs (compounded drug product) dispensed from the pharmacy to the injured employee on date of service January 28, 2016. The request for medical fee dispute resolution was received by the division on February 6, 2017, which is more than one year following the first disputed date of service.

   28 Texas Administrative Code §133.307(c)(1) requires that:

   > A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.
   > (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

   Review of the submitted documentation finds that the disputed services do not involve issues identified in Rule §133.307(c)(1)(B). The division concludes that the requestor has failed to timely file this dispute with the division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for the items dispensed on that date.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

For the reasons stated above, the division finds the requestor has waived the right to medical fee dispute resolution. The requestor has failed to support that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted documentation, in accordance with Texas Labor Code §413.031, the division has determined the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	March 10, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.